Illinois Department of Healthcare and Family Services

Augmentative Communication Systems Assessment Review Checklist

Patient Name: _____

Recipient Identification Number: _____

Are the following items completed/attached:

Prescription and Certification of Medical Necessity, including medical history information (from the primary care physician):

Yes_____No_____

Information Still Needed: _____

Completed Client Assessment Report:

Yes_____No_____

Information Still Needed: _____

Individual Treatment Plan:

Yes_____No_____

Information Still Needed: _____

Literature on Recommended Equipment:

Yes_____No_____

Information Still Needed: _____

Does the recommended system address the needs of the individual as indicated in the evaluation?

_____

_____

_____

_____

Will the client be able to approach the technological potential of the recommended system?

_____

_____

_____

_____

*Patient Name:*_____ *RIN:*_____

How will the system improve the effectiveness of the individual's communication?

_____

_____

_____

_____

What kind of support is available?

_____

_____

_____

Is the amount of training recommended adequate for the system recommended?

_____

_____

_____

Who will provide the training?

_____

_____

_____

Recommendation:

Approve_____Deny_____

Explanation for recommendation: _____

_____

_____

_____

_____

Reviewer: _____

Date: _____